WESTERN MINDANAO STATE UNIVERSITY
ZAMBOANGA CITY
UNIVERSITY HEALTH SERVICES CENTER
Tel. no. (062) 991-6736 / Email: healthservices@wmsu.edu.ph

PATIENT HEALTH PROFILE & CONSULTATIONS RECORD

(Electronic or Paper-based Input)

(Photo)	**Name:** Hadji, (Surname) Al-furqan (First name) Usman (Middle name)		
Age: 18	**Sex:** Male	**Course:** Civil engineering	**Year Level:** 1
Birthday *(MM-DD-YY)*: 06-13-2008		**Religion**: Islam	
Nationality: Filipino		**Civil Status:** Single	
Email Address: qanqanhadji92@gmail.com		**Contact #:** 09657708639	
City Address: Zone 1, Maasin Zamboanga city			
Provincial Address *(if applicable)*:			
Emergency Contact Person *within Zamboanga City*	**Name:** Norsana U. Hadji		
	Contact #: 0935 618 2297	**Relationship:** Mother	
	City Address: Zone 1, Maasin Zamboanga city		
Comorbid Illnesses	*Which of these conditions do you currently have?* ☐ Bronchial Asthma *("Hika")* ☑ Food Allergies (Specify food: Crab, Shrimp, squid) ☐ Allergic Rhinitis ☐ Hyperthyroidism ☐ Hypothyroidism/Goiter ☐ Anemia ☐ Psychiatric Illness: ☐ Major Depressive Disorder ☐ Bipolar Disorder		

<table>
<tr><td></td><td colspan="2">☐ Generalized Anxiety Disorder
☐ Panic Disorder
☐ Posttraumatic Stress Disorder
☐ Schizophrenia
☐ Other: _____

☐ Migraine (recurrent headaches)
☐ Epilepsy/Seizures
☐ Gastroesophageal Reflux Disease (GERD)
☐ Irritable Bowel Syndrome
☐ Hypertension (elevated blood pressure)
☐ Diabetes mellitus (elevated blood sugar)
☐ Dyslipidemia (elevated cholesterol levels)
☐ Arthritis (joint pains)
☐ Systemic Lupus Erythematosus (SLE)
☐ Polycystic Ovarian Syndrome (PCOS)
☐ Cancer (Specify:_____)
☐ Other: _____</td></tr>
<tr><td rowspan="6">Maintenance Medications</td><td>Generic Name of Drug</td><td>Dose and Frequency</td></tr>
<tr><td>1.</td><td></td></tr>
<tr><td>2.</td><td></td></tr>
<tr><td>3.</td><td></td></tr>
<tr><td>4.</td><td></td></tr>
<tr><td>5.</td><td></td></tr>
<tr><td>COVID-19 Vaccination</td><td colspan="2">☑ Fully vaccinated (Primary series with or without booster shot/s)
☐ Partially vaccinated (Incomplete primary series)
☐ Not vaccinated</td></tr>
<tr><td>Menstrual & Obstetric History
(for females only)</td><td>Age when menstruation began: _____
☐ Regular (monthly)
☐ Irregular
Number of pregnancies: _____
Number of live children:_____</td><td>Menstrual Symptoms:
☐ Dysmenorrhea (cramps)
☐ Migraine
☐ Loss of consciousness
☐ Other:_____</td></tr>
</table>

Past Medical & Surgical History

Which of these conditions have you had in the past?

- ☑ Varicella (Chicken Pox)
- ☐ Dengue
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Urinary Tract Infection
- ☐ Appendicitis
- ☐ Cholecystitis
- ☐ Other:_____

- ☐ Measles
- ☐ Typhoid fever
- ☐ Amoebiasis
- ☐ Nephro/Urolithiasis *(kidney stones)*
- ☑ Injury
  - ☑ Burn
  - ☐ Stab/Laceration
  - ☐ Fracture

Have you ever been admitted to the hospital and/or underwent a surgery?

☑ No	☐ Yes	
	Year:_____	Reason/s:_____
	Year:_____	Reason/s:_____
	Year:_____	Reason/s:_____

Family Medical History

Indicate the known health condition/s of your immediate family members.

- ☐ Hypertension *(elevated blood pressure)*
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Diabetes mellitus *(elevated blood sugar)*
- ☐ Chronic Kidney Disease (with/without regular Hemodialysis)
- ☐ Dyslipidemia *(elevated cholesterol levels)*
- ☐ Arthritis *(joint pains)*
- ☐ Cancer (Specify:_____)
- ☑ Bronchial Asthma *("Hika")*
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☑ Food Allergies (Specify food: Crab, shrimp, squid)
- ☐ Allergic Rhinitis
- ☐ Hyperthyroidism
- ☐ Hypothyroidism/Goiter
- ☐ Psychiatric Illness:
  - ☐ Major Depressive Disorder
  - ☐ Bipolar Disorder
  - ☐ Generalized Anxiety Disorder
  - ☐ Panic Disorder
  - ☐ Posttraumatic Stress Disorder

	☐ Schizophrenia ☐ Other: _____ ☐ Epilepsy/Seizures ☐ Other: _____

------- (For use by the University Health Services Center. Please do not fill out beyond this point.) -------

Height (cm):	**Weight** (kg):	**BMI:**
Physical Examination:		

Pre-Enrollment Health Assessment:

Chest X-ray Results: _____

CBC Results:_____

Blood Type:_____ Hepatitis B Screening Results (Antigen Test):_____

Urinalysis Results: _____

Others: _____

CONSULTATIONS RECORD

Date (mm-dd-yy)	**Signs & Symptoms**	**Vital Signs**	**Test Results**	**Diagnosis**	**Management**	**Nurse/ Physician In-charge**
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		RR:				
		Temp:				
		O2 sat:				
		BP:				
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